Margaret Lock, PhD Pamela Wakewich-Dunk, MA

Nerves and Nostalgia: Expression of Loss Among Greek Immigrants in Montreal

SUMMARY

The authors interviewed first-generation Greek immigrant women in Montreal about nonspecific somatic symptoms. The concept of *nevra* (nerves), which was central to these discussions, was used to link environmental and psychosocial variables with distress and painful physical states. The authors discuss the cultural construction of female identity in Greece and analyze the negative effect of immigration on self-esteem, often manifested as attacks of *nevra*. Metaphorical concepts, such as *nevra*, can be used to improve physician understanding and to facilitate communication with, and enhance care of, immigrant patients. (*Can Fam Physician* 1990; 36:253–258.)

RÉSUMÉ

Les auteurs ont interviewé la première génération des Immigrantes grecques installées à Montréal à propos de symptômes somatiques non spécifiques. Le concept de *nevra* (nerfs), qui constituait le point central de ces discussions, fut utilisé pour établir un lien entre les variables environnementales et psychosociales d'une part et la souffrance et les états physiques douloureux d'autre part. Les auteurs discutent de la structure culturelle de l'identité féminine en Grèce et analysent l'effet négatif de l'immigration sur l'estime de soi, lequel se manifeste souvent par des attaques de *nevra*. Les concepts métaphoriques tels *nevra* peuvent servir à améliorer la compréhension du médecin, faciliter la communication et améliorer la qualité des soins auprès des patients immigrants.

Key words: cross-cultural medicine, distress, family medicine, immigrant health care, neurology, psychiatry, somatization

Dr. Lock is at the Department of Humanities and Social Studies in Medicine, McGill University, Montreal. Ms. Wakewich-Dunk is at the Brief Psychotherapy Centre For Women, Women's College Hospital, Toronto. Requests for reprints to: Dr. Margaret Lock, McGill University, Department of Humanities and Social Studies in Medicine, 3655 Drummond St., Montreal, Que. H3G 1Y6

WHEN MARK ZOBOROWSKI first arrived at the Veterans Hospital in New York in the 1960s to discuss a research project on ethnic differences in response to pain, he was told that such a study would appear as racism. Such factors as duration of pain and site of the injury accounted for differing responses, he was told; to focus on ethnicity as a significant variable would be unscientific.[1] Zoborowski's study, however, demonstrated that, despite their claims to the contrary, health care personnel did indeed discriminate among ethnic groups in their responses to pain, to such an extent that there were significant differences in health care provision according to ethnic background.

In the Canadian mosaic of the 1980s, cultural differences in the experience, labelling, and meanings attributed to illness, attitudes toward the health care system, and differing expectations about therapy are more readily acknowledged than they were 20 years ago. A culturally sensitive health care system is now openly encouraged, not only among health professionals, but through financial support from the government (e.g., a federally funded program for the promotion of ethnically sensitive health care is in place at Children's Hospital in Montreal). The problem now becomes one of how to perform this delicate task with the benefit of only very little research.

We contend that some awareness and understanding of the value systems of patients are essential in this process. Exploring patients' theories about what caused their medical problems often exposes the world of the patient, family relationships, working conditions, religious beliefs, notions about anatomy and physiology, and ideas about the allocation of responsibility for the preservation of health and the incidence of illness.[2–4]

If narratives about causes are taken seriously, effective communication and health education are facilitated. At the same time, physician awareness of the social origins of many, perhaps most, illness episodes is heightened, which in turn has profound implications for patient care. In this paper we will use data on causal explanations given by Greek-Canadian immigrant women in connection with chronic, nonspecific somatic symptoms to show how such narratives provide a vicarious entree into the daily life of patients. We will then discuss the significance of these

findings, first for the care of Greek immigrants, and second for the promotion of a culturally sensitive medical practice in general.

Greek-Canadian Women in Montreal

The Greek population of Montreal is over 70 000 and is one of the largest outside of Greece. (The official census estimate for Montreal is only 35 000. The figure of 70 000 is estimated by members of the Greek community, who say that limitations with the way the census is conducted result in a poor representation of the size of their population.) The community is composed primarily of immigrants of rural origin who emigrated between 1941 and 1975. Greece experienced a Nazi occupation during the Second World War and 30 changes of government between 1944 and 1975, culminating in a right-wing dictatorship between 1967 and 1975. This political instability, coupled with regional struggles inside the country, caused great hardship involving the loss of land for large portions of the rural population, many of whom emigrated to Canada, Australia, and Germany, where the majority of immigrants are employed in semiskilled or unskilled jobs in the service and manufacturing sector.

Most of the women who participated in our study were employed as sewing machine operators in factories or were occupied with piece-work in their homes. Others were sales clerks, cleaners, waitresses, or housewives. Thirty per cent of the sample migrated from villages of under 1000 people. In all, 59% of the sample was of rural origin, 26% from small towns, and only 17% from metropolitan areas with populations of more than 50 000.

Data for this study were obtained from several sources: 83 first-generation Greek immigrant women living in Montreal were given structured interviews in their homes in which, in addition to basic socio-economic data, information was collected on ideas about health and illness causation, the importance of the family and social support networks in maintaining health and dealing with social problems, and the use of health care facilities.

The women were from 24 to 50 years of age, with a mean age of 35. Interviews were conducted in Greek. It became apparent during these interviews that the concept of *nevra* (nerves) was central to the narratives of virtually all respondents. This term was used to link environmental and psychosocial variables to distress and painful physical states.

In the second phase of the research, 19 women from the original group were selected for in-depth, open-ended interviews in which *nevra* was discussed in detail. A further data set was obtained from 25 women who were interviewed in the office of a Greek-Canadian general practitioner and 15 more attending a poly-clinic in a Montreal teaching hospital. These interviews were conducted to learn whether *nevra* was used as a presenting complaint in clinical settings. Finally, we also interviewed several physicians and social workers who had daily contact with Greek patients. From these data we obtained an elaborate picture of *nevra*, including its significance as a tool for enhancing communication with Greek immigrants. We believe that *nevra*, and parallel concepts in other languages that are used to make statements about the relationship of individual body states to variables external to the body, such as family relationships or working conditions, are key concepts for the creation of culturally sensitive primary health care.

Attacks of Nerves

Nevra is usually described as a feeling of loss of control, of having one's nerves "burst out" or "break out" or "boil over." An attack is often accompanied by shouting or screaming and throwing things. Headaches, dizziness, pain, and feelings of melancholy are associated with *nevra*. (In its original Greek sense, melancholia is characterized by anxious concern and sullen suspiciousness; the condition is thought of as involving both mental and physical disturbances.[5]) Women had the following to say on the subject:

> When you have *nevra* you are very, very different—you are not yourself. Your head hurts, you are tense all over. You scream and shout.
>
> *(housewife, aged 42)*

> When I have *nevra* I feel like killing a person, in a manner of speaking. It helps if I shout or scream. To be truthful, when I have *nevra* I cry a lot.
>
> *(housewife, aged 27)*

> I feel as though I am boiling inside. I want to hit the small ones so I must leave the children when I have *nevra*.
>
> *(housewife, aged 32)*

"Getting nerves" is regarded as normal, although an unpleasant and disvalued affect. Some people are said to be more constitutionally or temperamentally vulnerable than others to attacks. Women are believed to suffer from the condition more than men, and virtually all of the respondents stated that it occurs more in Canada than in Greece; its increased incidence is explicitly linked with the immigrant experience.

It is only when *nevra* becomes chronic and disabling that women take on the sick role and seek medical help. In clinical settings, not surprisingly, their complaints focus more on physical symptoms, which often include sharp or stabbing pains in the chest or the base of the skull, in addition to other nonspecific symptoms.

We translated the Cornell Medical Index (CMI) into Greek and administered it to 29 women in the sample in both family and clinical settings.[6] More than 25 items were checked as positive by 23 of the women. This score usually indicates that a serious disorder should be suspected. Thirteen women had checked 60 or more items, and two of these had checked over 100. The "yes" responses were scattered throughout the CMI, indicating that the problem was "diffused" and that an emotional disturbance was probably involved.

All 23 women who had marked more than 25 items, and an additional three of the remaining six women, had marked more than three items in the final portion of the CMI, which is designed to elicit responses in connection with moods, attitudes, and behaviour. More than three responses usually indicates a psychological disturbance. Six women marked 30 or more items in the final portion of the questionnaire, another three marked 20 or more, and a further 13 marked more than 10 items. Of 10 male Greek immigrants who were tested at the same time, only four had scores within the normal range; four had borderline scores between 20 and 28 (including between three and five items in the final portion of the CMI), and four had scores with significant elevations in the final part of the questionnaire.

Somatization among Greek immigrants, women in particular, has been noted. Moraitis and Zigouras report high rates of depression, anxiety, and psychosomatic problems among their patients of Greek origin in Australia. They attribute these problems to "inse-

curity and a fear of dying in a foreign country."[7] Two Canadian studies also report physician statements to the effect that there is a propensity for somatization among Greek patients, to the extent that it could be considered as an "ethnic characteristic."[8,9]

Similar results were found with 60 women of Greek origin in Chicago whose "psychophysiologic manifestations" and "gross stress reactions" are said to be the result of unresolved mother-daughter attachments, which the authors label the "Persephone syndrome." Women's statements about poverty, language difficulties, and marital problems as causes of physical symptoms are dismissed in favour of a psychodynamic approach where efforts are made to "direct responsibility back to the individual member. . . by shifting the focus from external factors to the individual's own negative motivations".[10]

The CMI results in our study appeared to support these earlier findings; in contrast to the approach taken in the Chicago study, however, we believe that the social and political reality of immigrant women entails so many tangible losses, both material and psychological, that to dismiss variables external to the individual as irrelevant is not only inappropriate but irresponsible. Moreover, while diagnoses of anxiety, depression, or panic attack may well be appropriate in many cases, and although some women benefit from medication, physicians who were interviewed in this study assured us that many women cannot be readily diagnosed, nor do they all benefit from antidepressants or tranquilizers, which are in any case often viewed as a temporary measure by both physicians and patients.

Somatization can best be defined as "both the expression of physical complaints in the absence of defined organic pathology and the amplification of symptoms resulting from established physical pathology (e.g., chronic disease)."[11] It has been hypothesized that whether one uses predominantly psychological or physiological modes for the expression of distress depends upon two major determinants:

> . . . actual adult experiences with symptoms and illness on the one hand, and cultural influences on the definition of illness on the other. Whereas reporting physical symptoms is culturally more neutral, reporting psychological symptoms is more dependent on social acceptability.[12]

Research by both physicians and anthropologists indicates that the body is habitually used symbolically as a vehicle for expressing stress and oppression. The form of the expression is culturally constructed and can range from a dramatized performance or ritual to altered states of consciousness (in Africa, the Caribbean, and South East Asia, for example), from direct verbalization of the problem to more subtle forms of somatization in which the corporeal body rebels. These symbolic representations can be interpreted in a negative light, as forms of deviance or disease. They can also be regarded as a plea for help and for a release from the drudgery or humiliation experienced when one's lot in life is truly unbearable.[13–15]

Two case studies, cited below, introduce a cultural analysis of *nevra* and the causes described by Greek women. Perhaps it is appropriate to reiterate that, although the description that follows may seem highly elaborate, we chose not to truncate it to demonstrate the importance and complexity of both social and cultural variables for health and illness. In the concluding discussion, we will consider what must inevitably be a question in the minds of practising physicians: how does one generalize from this wealth of detail? It is clearly impossible to become acquainted in depth with every ethnic group now living in Canada.

Case 1

Panagiota was 44 years old, married, and had three children aged 22, 20, and 18. She came to Canada when she was 16, and had worked ever since as a domestic. She received schooling to the grade three level.

Panagiota had chronic problems with *nevra*, which she said manifested as headaches and pain in the back of the head that radiated down the back. She confessed to screaming very often and to fighting with her husband and children. She described herself as "tired and nervous" and as "having a fear inside me" and then went on to describe a recurring dream: "I am fighting to the last by myself. There is nobody there to help me. I find myself somewhere in the desert with no way to return. And I see that dream more and more and more."

Panagiota had no extended family in Canada. She had one brother, with whom she was very close, who died shortly before the interview. She was unhappy with her marriage and claimed that her husband was always mad and screaming. She felt like a prisoner in her own house because her husband rarely allowed her out alone. She also felt trapped trying to mediate between her traditionally minded husband and their Canada-raised children.

Panagiota had seen several physicians over the years and had taken many different kinds of medication. Despite numerous tests, she said, "No one can find anything wrong with me. I don't understand why. I am sick. I feel sick." She liked her current doctor, whom she described as very sympathetic. "I feel sorry for him," she said, laughing, "he is trying so hard to help me and I come to see him so often." Panagiota was taking diazepam at the time, but was unimpressed with its effects. She used her visits to the physician to validate her sick role in her own mind and with her sceptical husband.

Case 2

Maria was 55, married, and the mother of three children older than 20 years of age. She came to Canada in 1952 and was originally employed as a domestic, but soon obtained a job in the garment industry, where she was employed until 1 1/2 years ago, when she was dismissed for being "too old." She stated, "I do a good job, I am a good operator. It's just my age that is no good." Her unemployment insurance had recently run out and she was essentially unemployable at her age.

Maria identified herself as a "nervous type" and attributed her recent, repeated nosebleeds to *nevra* caused by poverty and a difficult family situation. Maria said that, until recently, her husband was a gambler and that she was always left alone with the children in the house while he went out. "That's the Greek way," she stated, "They leave the family alone and the wife is with the kids like a slave." For the past two years, her husband had stopped gambling, but the family situation had not improved: "He stays in the house now and makes me nervous. He doesn't like to go out with me much. He would like to be out by himself, to be free. That's how Greek men are."

These accounts, with their emphases on marital discord and isolation, are similar to those of immigrant women from many different backgrounds, but

they take on new significance in light of ethnographies about rural Greek life.

Honour, Shame, and Sex Roles

In common with many other societies of the world,[16,17] Greek culture presumes a relationship between a healthy and "correct" human body, a clean and orderly house, and moral order in society at large. The house is the focus of family life in Greece, not only in terms of furnishing all the physical and social needs of family members, but also in terms of spiritual needs, forming a centre replete with icons and regular ritual activity where family members seek to emulate the Holy Family.[18]

Management of the house is the special responsibility of the woman, who is both functionally and symbolically associated with it.[19] Cleanliness and order in the house are said to reflect the moral character of the woman, and a discussion of private, "inside" family matters should not cross the threshold into the threatening domain of the outside world. Ideally, a woman should never leave the house for frivolous or idle reasons and venture outside where dirt and immorality abound. A woman who spends too much time out of the house can be accused not only of neglecting her household duties, but is suspected of illicit sexual activity or gossip, either of which can damage the all-important social reputation of her family.

Just as a distinction is made between inside and outside the house, so too is a distinction made between the inner and outer body.[20] Contact must be avoided between what goes into the body and what comes out of it. Dirty clothes and polluting human waste must be strictly segregated from food preparation. While the fulfillment of men's sexual needs is considered imperative, a woman's life is hedged with taboos about menstruation, marriage, the sexual act, and childbirth, designed to combat her supposed innate negative characteristics, mute her sexuality, and contain the pollution of her body products. Dubisch postulates a parallel between the kitchen and the vagina:

> The kitchen, the point of entry into the house, is protected by the porch, an area for collecting or deflecting dirt, just as entry into the woman is protected both by modest clothing and the propriety of her own deportment, which deflects improper sexual advances or gossip. Both kitchen and sexual entryway are subject to cultural rules regarding the passage of substances, rules that serve to turn a natural product or impulse into a culturally approved one.[21]

A woman who conducts herself appropriately, therefore, is responsible for the maintenance of cleanliness, order, and harmony in both her personal conduct and the household. Her task is to bind the family unit together, keep it ritually pure, and protect it from the potentially destructive outside world.[22] Together with the raising of children, this role is the prime source of a Greek woman's pride and self-esteem.

Relationships among Mediterranean families have been described as competitive, not only in economic advancement but also in the honour of the family. The everyday behaviour of Greek men and women is characteristically organized around the concepts of honour and shame.[23] There is regional variation in the elaboration of these beliefs, but the assumption that men should protect the family honour through their *filotimo* (manliness), while women must show *dropi* (sexual modesty) is generally accepted. Men are responsible for the behaviour of the women in their family, and a woman's body "becomes the symbol of family integrity and purity and, more generally, of society as a whole."[19]

The opposition between inside and outside set up unresolvable contradictions for Greek women. As part of the maintenance of honour and prestige, it is expected that a family should keep up an active social life and be "open," an auspicious state that is actively sought after.[16] For a woman, however, "openness" is a potentially dangerous state equated with a lapse of sexual modesty. Ideally, women should be "closed" and controlled. Paradoxically, for many this becomes associated with feelings of illness, with withdrawal, melancholy, and depression, the Greek word for which is *stenahoria* (literally, a "narrow place"). A woman who becomes too "closed" and withdrawn is thought of as antisocial and cold. Women, therefore, spend considerable energy trying to preserve a suitable equilibrium between inside and out, open and closed.

Classic Galenic concepts of health and causes of illness promote balance and moderation for health maintenance: excesses of worry, work, food, and alcohol, and sudden changes in environmental conditions should be avoided. Emotional stability is also highly valued, so that loss of control, and most particularly feelings of bursting out of one's body, of blurring inside and outside, are feared and thought to contribute to illness. *Nevra* is the concept used to mediate between distressing social events, disvalued emotional states (a sensation of loss of control, of confinement and withdrawal, or of both) and somatic symptoms.

Loss of Traditional Values

Traditional values are not abandoned with immigration; on the contrary, the uncertainties produced by a new life can promote them. Greek women in Montreal often complain that they seldom have an opportunity to get out of the house unaccompanied by their husbands except to go to and from work and the supermarket. A Greek-Canadian physician described many of his patients as suffering from the "hostage syndrome."

In traditional life, women's subordination to and dependence on men is curtailed by numerous social supports. For example, a man who is too harsh with his wife will be chastised by the community. Moreover, women derive strength and friendship from female relatives. Cramped apartment life in Montreal, often with no relatives in the same city, leads to a greater dependence of women on their husbands than in Greece, especially because they have virtually no opportunities to learn either French or English.

In addition to unwanted feelings of dependence, themes of isolation and nostalgia ran through the stories in which women accounted for *nevra*. The combination of a small apartment and the Montreal climate added to a sense of loss and confinement when compared with the warmth of an airy Greek house. Many people had their house and land forcibly taken from them before they decided to come to Canada; others simply chose to emigrate, usually in search of financial security, a dream that rarely materializes in one generation.

The women we interviewed spoke with great longing for their homeland and mourned their homes and gardens, where they had maintained a self-sufficient lifestyle and from which they had derived much pride. Their other traditional source of self-esteem was also irreparably damaged with immigration: women cannot control to any great ex-

tent the socialization of their Canadian children, who grow up with a very different value system from their parents.

While cultural factors shape the expression of *nevra*, it is important to know the social situation of recent Greek immigrants to fully understand the concept of *nevra*.[24]

Immigrant women form a captive labour force for the service and manufacturing sector in Montreal because of their immediate need for employment, low level of education, and lack of fluency in either of the official languages. Studies of the garment factories indicate that rates of pay are low, the work environment poor (high noise levels, extreme temperature changes, poor ventilation), and that jobs are highly stressful because many employees work on a piece-rate. There is little job security, and the work is seasonal with periods of intense employment followed by long periods of unemployment.

This situation is compounded by what women describe as the "double workday," whereby they are made solely responsible for the running of the household in addition to taking paid employment. Immigrant women in general suffer from the injustices practised by the garment industry, but the traditional Greek value system exacerbates the situation. Both men and women are fearful when a Greek woman has to work outside the house; concerns about honour and sexual propriety create extra tensions.

Poor economic conditions and pressures at the workplace are not limited to women, but task differentiation by gender occurs both on the shop floor and in the union structure, making women more vulnerable to exploitation.[25,26] The few skilled jobs, those of the cutters for example, are held by men. A two-tiered system of union bargaining often takes place, by which good contracts are secured for male workers at the sacrifice of their female co-workers.[27] Women who do homework (piece-work in the home) face an even more difficult situation. Although it is in theory possible to care for one's children while working, the isolation, rapid pace of work demanded by employers, and financial insecurity create unrelieved pressure.

Lack of companionship in Montreal is also cited by the women as yet another loss associated with migration. The structure of the Greek organizations in Montreal are such that traditional political factions dominate them, and there is little opportunity for women to make friendships through these groups. Most respondents identify themselves as Greek Orthodox (92%), but virtually every respondent stated that the church has no role today in either health or social problems.

Women themselves cite numerous causes for *nevra*, including, most often, poverty and working conditions, followed by the behaviour of husbands or children, feelings of isolation or anxiety, nostalgia for Greece, or lack of familiarity with French or English. Discussing these etiological statements with women indicates that a feeling of a lack or loss of control precipitates frequent bouts of *nevra*.

The ambivalence that women feel about their social situation is sometimes manifested as alternating bouts of *stenahoria* (feelings of confinement and depression) with agoraphobia, so that *nevra* can occur as a result of feelings of isolation or, in contrast, when the family is all dressed up and ready to go out together.

Discussion

When Greek women refer to *nevra* in daily conversation, they are describing a sensation, usually of boiling over, that is associated metaphorically rather than literally with the nerves. This normal experience is thought to be the result of a lack or loss of control over social events or of anxiety about unpredictable future events. If bouts of *nevra* become chronic, particularly when pain is involved, the term takes on a more literal meaning in addition to its metaphorical one. Sites of pain can be pointed out very readily by patients who visit their doctor's office for relief from debilitating symptoms.

The immigrant experience puts Greek women at great risk for chronic disease because their multiple losses, coupled with increased dependence and isolation, heighten feelings of lack of control. In common with most cultures around the world, in traditional Greece the culturally acceptable way to express a chronic state of distress is by focusing attention on somatic symptoms, and this is particularly true of the powerless. To regard this behaviour as deviant or pathological is inappropriate; on the contrary, when viewed in cultural context it makes eminent sense. To openly verbalize one's problems would be self-destructive; in fact, such behaviour could more appropriately be considered as a sign of disease.

Nevra is perhaps best conceived as a culturally constructed form of communication that can serve to induce change in the behaviour of those around one. When the message goes unheeded, however (as is inevitably the case when *nevra* is a response to uncontrollable losses or faceless oppressors, such as landlords and employers), *nevra* becomes a statement about chronic distress, lack of dignity, and low self-esteem.

Given the multiple losses and unhealthy work conditions with which immigrant women must live, we believe that it is inappropriate to accuse them of not adapting successfully to Canada. In retrospect, to remain with their rural lifestyle in Greece may well have been the healthiest choice. In a similar vein, to encourage them to internalize their problems and to promote self-responsibility seems at best a partial solution, because they are in no way responsible for the working conditions in Montreal factories, nor even for the behaviour of their husbands.

Recommendations for Care

It seems appropriate to attend to women's complaints because they usually visit a physician only when they believe their problem to be severe. At the very minimum, acknowledging much of their distress as being caused by political and social circumstances and empathy with their situation would be therapeutic. Acceptance of the term *nevra* as a meaningful concept could facilitate communication and heighten one's ability to produce a genuinely supportive response to patient narratives.

Clearly a ruling out of clinical depression or anxiety states is in order, and this of necessity entails a translation of *nevra* into medical language. While taking a family history, however, asking patients directly what they believe is the cause of *nevra* could be very enlightening. Encouraging patients to talk about memories of their lives in Greece and of their immigration experience will validate the important role that past events continue to play in their lives. At the same time, this exercise may serve to diffuse some of the feelings of excessive nostalgia.

Discussion about the workplace is much more easily accomplished than is discussion about family relationships because no outsider should gain access

to Greek family life. Physicians in this study stated that they could obtain information about family dynamics only after repeat visits and establishing close rapport. Indeed, discussion of family matters by a patient can potentially induce enormous guilt and possible retribution from an angry husband whose honour has been tarnished. Further, passing patients over to social workers or psychologists for follow-up visits is inappropriate. While most of the respondents in our study respect and trust physicians, they are highly suspicious of social workers and do not as a rule co-operate with them.

Any direct suggestion that the problem is primarily a psychological one is also inappropriate because mental illness is highly stigmatizing. In fact, the reason some women come to the family physician is to receive medication to prove that their problem is not "in their head." If the patient does not have a major mental problem, or indeed any other major physical problem, she will be very reassured to hear it.

It should also be noted that, in Montreal, at least, the Greek community is not unified. Different waves of immigration and political factions and divisions based upon place of origin in Greece constantly work against integration in Canada. These schisms have served to thwart any attempts by the community to set up self-help groups in order to empower immigrant women. One way to circumvent this situation would be to arrange for groups of two or three women, ideally born in the same part of Greece, to get together informally. Because their isolation prevents women from having much contact with one another, the simple task of arranging an introduction could be of great therapeutic value.

Conclusions

In all languages, certain terms are used to establish links between social events, emotional states, and somatic sensations. In contemporary North American parlance, "stress" is the term most often used, a word with a pseudo-scientific ring in keeping with the dominant orientation of our culture. Most of the cultural regions where Galenic medicine gained a strong foothold use some variation of "nerves"; some African peoples make reference to the state of their skin in order to express states of distress, and both Chinese and Japanese have a traditional language with which to describe the relationship of one's body to society at large.

We believe that, if these terms are taken seriously as rich, graphic expressions about emotional states and important events in the lives of patients, we will have taken a major step toward culturally sensitive health care. Only thus can one catch a glimpse into the complex world of another culture, or experience briefly what it is like to be poor and exploited. In contrast, an approach that merely documents the quaint customs and superstitions of other peoples is not only condescending, but actually a liability in the development of empathy, understanding, and an effective therapeutic encounter. ■

Acknowledgements

Funding for this research was provided by a grant from the Social Sciences and Humanities Research Council of Canada.

References

1. Zoborowski M. *People in pain.* San Francisco: Jossey-Bass Inc., 1969.

2. Kleinman A. Recognition and management of illness problems: therapeutic recommendations from clinical social science. In: *Mass. Gen. Hospital review for physicians: psychiatric medicine update.* New York: Elsevier, 1979:23–31.

3. Good BJ, Good MD. The meaning of symptoms: a cultural hermeneutic model for clinical practice. In: Eisenberg L, Kleinman A, eds. *The relevance of social science for medicine.* Dordrecht: D. Reidel Publishing Co., 1981:165–96.

4. Lock M. The relationship between culture and health or illness. In: Christie–Seely J, ed. *Working with the family in primary care: a systems application to health and illness.* New York: Praeger Pub. Inc., 1984.

5. Simon B. *Mind and madness in ancient Greece: the roots of modern psychiatry.* Ithaca, NY: Cornell University Press, 1978.

6. Brodman K, Erdmann AJ Jr, Wolff HG. *Cornell medical index: health questionnaire.* New York: Cornell University Medical College, 1974.

7. Moraitis S, Zigouras JN. Impressions of Greek immigrants. *Med J Aust* 1971; 13:598–600.

8. Government of Ontario. *Papers on the Greek community.* Toronto: Ministry of Culture and Recreation, Multicultural Development Branch, 1977.

9. Patterson JG. *The Greeks of Vancouver* (paper no. 18). Ottawa, Ont.: National Museum of Man, Mercury Series, Centre for Folklore Studies, 1976.

10. Dunkas N, Nikelly G. Group psychotherapy with Greek immigrants. *Int J Group Psychother* 1975; 25:402–9.

11. Kleinman A. Neurasthenia and depression. *Cult Med Psychiatry* 1982; 6:117–90.

12. Mechanic D. The experience and reporting of common physical complaints. *J Health Soc Behav* 1980; 21:146–55.

13. Comaroff J. Medicine: symbol and ideology. In: Treacher A, Wright P, eds. *The problem of medical knowledge.* Edinburgh: Edinburgh University Press, 1982: 49–68.

14. Devisch R. Symbol and psychosomatic symptom in bodily space-time. *Int J Psychol* 1985; 20:396–412.

15. Lock M. Plea for acceptance. *Soc Sci Med* 1986; 23:99–112.

16. Griaule M. *Conversations with Ogotemmeli.* Oxford: Oxford University Press, 1965.

17. Hugh-Jones C. *From the milk of the river: spatial and temporal process in Northwest Amazonia.* Cambridge: Cambridge University Press, 1979.

18. DuBoulay J. Women—images of their nature and destiny in rural Greece. In: Dubisch J, ed. *Gender and power in rural Greece.* Princeton, NJ: Princeton University Press, 1986:139–68.

19. Dubisch J. Culture enters through the kitchen: women, food, and social boundaries in rural Greece. In: Dubisch J, ed. *Gender and power in rural Greece.* Princeton, NJ: Princeton University Press, 1986:195–214.

20. Dubisch J. Greek women: sacred or profane? *J Mod Greek Studies* 1983; 1(1):185–202.

21. Dubisch J. The city as resource: migration from a Greek island village. *Urban Anthropol* 1977; 6(1):65–81.

22. DuBoulay J. *Portrait of a Greek mountain village.* Oxford: Clarendon Press, 1974.

23. Campbell JK. *Honour, family and patronage: a study of institutions and moral values in a Greek mountain community.* Oxford: Clarendon Press, 1964.

24. Dunk P. My nerves are broken: the social relations of illness in a Greek–Canadian community [M.A. thesis]. Montreal: McGill University, 1988. p. 155.

25. Gannage C. *Double day, double bind. Women garment workers.* Toronto: The Women's Press, 1986.

26. Teal G. The organization of production and the heterogeneity of the working class: occupation, gender and ethnicity among clothing workers in Quebec [Ph.D. Thesis]. Montreal: Department of Anthropology, McGill University, 1985. p. 529.

27. Arnopoulos SM. *Problems of immigrant women in the Canadian labour force.* Ottawa, Ont.: Canadian Advisory Council on the Status of Women, 1979.